New Hampshire

SPIRIVA®

NH Medicaid Prior Authorization Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

Section I: Patient Information and Medication Requested

Name: (Last, First) _____

NH Medicaid Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Section II: Clinical History

1. Patient's Diagnosis: _____
2. Has the patient experienced a treatment failure with ipatroprium (Atrovent® or Combivent®) at a maximum of 12 inhalations per day? ☐ Yes ☐ No
3. What is the patient's FEV_1/FVC?_____
4. Has there been a diagnosis of moderate to severe COPD according to GOLD criteria[1] as listed in table below? ☐ Yes ☐ No

   If **Yes**, please indicate which stage by checking the box, in the table below, that corresponds to the treatment failure:

Classification of Severity (GOLD Criteria[1])

	STAGE	CHARACTERISTICS
	At risk	Normal Spirometry Chronic symptoms (cough, sputum production)
	Mild COPD	FEV_1/FVC <70% $FEV_1 \geq 80\%$ predicted With or without chronic symptoms (cough, sputum production)
	Moderate COPD	FEV_1/FVC <70% $50\% \leq FEV_1 < 80\%$ predicted With or without chronic symptoms (cough, sputum production)
	Severe COPD	FEV_1/FVC <70% $30\% \leq FEV_1 < 50\%$ predicted With or without chronic symptoms (cough, sputum production)
	Very Severe COPD	FEV_1/FVC < 70% FEV_1 < 30 % predicted or FEV1 < 50% predicted plus chronic respiratory failure

Classification based on postbronchodilator FEV_1

- FEV_1: forced expiratory volume in one second
- FVC: forced vital capacity,
- respiratory failure: arterial partial pressure of oxygen (PaO_2) less than 8.0 kPa (60 mm Hg) with or without arterial partial pressure of CO_2 ($PaCO_2$) greater than 6.7 kPa (50 mm Hg) while breathing air at sea level.

[1] National Institutes of Health, National Heart, Lung and Blood Institute global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. NHLBI/WHO Workshop Report, update 2003. http://www.goldcopd.com/.

SECTION III: Prescriber Information

Name: _____ DEA Number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Phone #: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____ Fax #: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Signature of Prescribing Provider